2005 SCORING GUIDELINES

CONSUMER REPORTING METHODS FOR OFFICE OF PATIENT ADVOCATE AND PBGH HEALTHSCOPE

Contents:

HEDIS 2005 SCORING GUIDELINES

CONSUMER REPORTING METHODS FOR OFFICE OF PATIENT ADVOCATE AND PBGH HEALTHSCOPE

I. Eligible Measures and Plans

The eligible measures consist of the California Cooperative HealthCare Reporting Initiative's (CCHRI) publicly reported HEDIS* commercial measures for reporting year 2005. Reporting year 2005 results are the primary data source. Reporting year 2004 results are used for those rotated HEDIS measures for which plans opt not to report 2005 results. Plans have the option of using the 2004 results or reporting 2005 results for the rotated measures.

There are 10 participating health plans that are reporting HEDIS results; Western Health Advantage and Universal Care are reporting HEDIS results thought these plans do not participate in the CCHRI HEDIS work. See Appendix E for a list of the participating plans.

Performance results are reported at a health plan reporting unit level – the plans report a single, statewide set of performance results; Kaiser Northern California and Kaiser Southern California are the exception to this rule.

II. Measures Categorization

Three summary performance categories were created by mapping the HEDIS measures into three relevant consumer topics. See the detailed mapping in Appendix A below.

1. Staying Healthy
2. Getting Better
3. Living with Illness

* Health Plan Employer Data and Information Set (HEDIS). NCQA sponsors and maintains the HEDIS performance measures as the national standard set of clinical process and outcomes health plan measures.

III. Handling Missing HEDIS Data

In instances in which the HEDIS measure is classified as Not Applicable (NA), we remove the measure from the category score and calculate the score using only the remaining measures. The weights for this category are recalculated for the plan in question to reflect only the reported scores.

In instances in which the HEDIS measure is classified as Not Reported (NR) we apply a rule of using the prior year's result for that measure. If the measure was Not Reported (NR) for the prior year a score of zero is assigned as the measure result.

IV. Scoring

All of the performance results are expressed such that a higher score means better performance.

Individual Measure Scoring

The HEDIS individual measure scores are calculated as proportional rates using the numerators and denominators that are reported per the NCQA measurement requirements. The HEDIS measure results are converted to a score using the following formula:

(HEDIS measure numerator/HEDIS measure denominator)*100

Measures Categorization

See Appendix A for the categorization of measures into each of the three summary performance topics.

Summary Performance Category Scoring

Each individual measure score is converted to a 0-100 scale to aggregate the individual measures to their respective summary performance score. The summary performance score is the mean of the individual proportional scores that are mapped to a given category. The HEDIS measures, which are proportional rates, translate directly as 0-100 rates.

The summary scoring process is a two-step method. In step 1, measures that either share the same population as the denominator or are closely related measures (e.g. asthma medication measures stratified by age group) are blended per the weights ('component measure wgts') in Appendix B. In step 2 the measures are aggregated into summary scores per the second set of weights ('2005 wgts') in Appendix B.

The weighted scores apply the weights shown in Appendix B Tables 1-3 to the scores, by multiplying each rate by the weight expressed as a decimal (e.g., a weight of 10 is scored as .10), summing, and multiplying by 100.

2005-Specific Scoring Notes

1. Flu Vaccination for Older Adults (age 50-64) measure, which is drawn from the CAHPS survey, is not included in the Staying Healthy public reporting due to uncertainties arising from the earlier flu vaccine shortage.

2. NCQA Rotated Measures
   - Use any rotated measure result for reporting year 2005 that is reported by a health plan to NCQA (see footnote Appendix A).
   - For plans that do not report on a rotated measure use the plan's most recent measure score from a prior reporting year.
   - The 2005 measures that were eligible to be rotated are:
     - Cholesterol Management LDL Screening
     - Cholesterol Management LDL Control
     - Childhood Immunization Combo 1
     - Adolescent Immunization Combo 1
     - Beta Blockers

3. The LDL control measures are based on LDL < 130 mg/dL level

4. Three measures are being publicly reported for the first time in 2005:
   - Colorectal Cancer Screening
   - Appropriate Treatment for Children with Upper Respiratory Infection
   - Appropriate Testing for Children with Pharyngitis

V. Sampling Error Testing

Any score that lies within the two extreme performance grades (excellent or poor) is tested to determine if that score is significantly different ($p < .05$) than the all-HMO mean score for that performance category (e.g. Staying Healthy). Scores that are not significantly different than the mean (the confidence limit for the plan in question must not be different from the mean score) are reclassified in the adjacent performance grade so a poor grade would be shifted to fair and an excellent grade shifted to a good. See Appendix F for the description of the statistical test.

VI. Performance Grading

A grade is assigned to each summary performance score – each HMO's performance is characterized by three performance grades representing three subsets of the HEDIS measures; in addition the individual measures results are presented.

An absolute grading approach is used to assign grades for the three HEDIS summary performance categories. Each of the plan's summary performance scores are assigned a grade based on the position of the actual score relative to a set of performance thresholds on a 0-100 scale (e.g., scores lower than 60 are 'poor' performance). The performance cutpoints, detailed in Appendix C, are absolute not relative markers of performance.

Appendix A
2005 HEDIS Measures Category Mapping and Reporting Year Data Source

Table 1. Staying Healthy: Performance Category Mapping

Indicator	Definition	Reporting Year
Colorectal Screening	% of adults, ages 50-80, who were tested for colorectal cancer using any one of four tests	2005**
Adolescent Immunizations (combination 1)	% of adolescents who by 13th birthday received second dose MMR and Hepatitis B vaccinations (combo 1)	2005*
Childhood Immunizations (combination 1)	% of children who receive 3 HiBs by 2nd birthday (at least 1 of 3 between 1st and 2nd birthday); and 1 Varicella vaccination between 1st and 2nd birthday; DtaP/DT regime, 3 polio (IPV) before age 2, 3 hepatiitis B by 2nd birthday and 1 MMR between 1st and 2nd birthday	2005*
Chlamydia screening 1	% of sexually active women aged 16-20 who were screened for chlamydia in prior year	2005
Chlamydia screening 2	% of sexually active women aged 21-25 who were screened for chlamydia in prior year	2005
Breast cancer screening	% women age 52-69 who had a mammogram during past two years	2005
Cervical cancer screening	% women age 21-64 who had a Pap test during past three years	2005
Pre natal visit during 1st trimester	% pregnant women who began prenatal care during the first 13 weeks of pregnancy	2005
Postpartum care	% women who had a live birth who had a postpartum visit between 21-56 days after delivery	2005

* 2005 rotation measure; plans have option of reporting a 2005 measure result; if no 2005 result is reported use 2004 result

**First year measure for public reporting

Table 2. Living with Illness: Performance Category Mapping

Indicator	Definition	Reporting Year
Appropriate asthma medications 1	% of children aged 5-9 with asthma who have appropriate asthma medications	2005
Appropriate asthma medications 2	% of children aged 10-17 with asthma who have appropriate asthma medications	2005
Appropriate asthma medications 3	% of adults aged 18-56 with asthma who have appropriate asthma medications	2005
Controlling high blood pressure	% adults diagnosed hypertension whose blood pressure was controlled	2005
Glycosylated hemoglobin tested	% diabetes patients who had an HbA1c test in last year	2005
Glycosylated hemoglobin control	% diabetes patients whose HbA1c <= 9.5 (confirm recode)	2005
Eye exam performed	% diabetes patients who had a retinal eye exam in last year	2005
Cholesterol test performed	% diabetes patients who had an LDL test in last year	2005
Cholesterol control	% diabetes patients whose LDL level <130mg/dl	2005
Kidney function monitored	% diabetes patients who had nephropathy screening test in last year	2005

* 2005 rotation measure; plans have option of reporting a 2005 measure result; if no 2005 result is reported use 2004 result

Table 3. Getting Better: Performance Category Mapping

Indicator	Definition	Reporting Year
Follow-up 7 days after hospitalization for mental illness	% patients who were hospitalized for a mental illness who had an outpatient visit with a mental health provider within 7 days after discharge	2005
Follow-up 30 days after hospitalization for mental illness	% patients who were hospitalized for a mental illness who had an outpatient visit with a mental health provider within 30 days after discharge	2005
Anti-depressant medication management 1	% depressed patients who received at least 3 outpatient visits during 12-week acute treatment phase	2005
Anti-depressant medication management 2	% depressed patients who remained on antidepressant medication for the 12-week acute treatment phase	2005
Anti-depressant medication management 3	% depressed patients who remained on antidepressant medication for the six month continuation phase	2005
Beta blockers	% of persons post-mi who received beta blockers medication	2005*
Cholesterol management 1	LDL screening after acute cardiovascular event	2005*
Cholesterol management 2	LDL level < 130 mg/dl after acute cardiovascular event	2005*
Testing for Upper Respiratory Infection	% of children, ages 3 months to 18 years, who had an upper respiratory infection (common cold), who were not given an antibiotic – medicines	2005**
Testing for Pharyngitis	% of children, ages 2-18, who were diagnosed with pharyngitis (throat infection) and given an antibiotic medication, who were tested for strep throat	2005**

* 2005 rotation measure; plans have option of reporting a 2005 measure result; if no 2005 result is reported use 2004 result

**First year measure for public reporting

Appendix B
2005 HEDIS Weights

Summary Category	Component Measures**	Measures Scored in Rollup	2005 Wgt.
Staying Healthy		Childhood Immunization Combo 1	20
		Adolescent Immunization Combo 1	10
		Colorectal Cancer Screening	20
		Breast Cancer Screening	10
		Cervical Cancer Screening	20
		Chlamydia Screening	10
	Ages 16-20 (.5)		
	Ages 21-25 (.5)		
		Prenatal/Postpartum Care	10
	Prenatal Visit (.66)		
	Postpartum Visit (.33)		
			100
Getting Better			
	Optimal Practitioner Contacts (.33)	Antidepressant Medication Management	12.5
	Acute Phase Treatment (.33)		
	Continuation Phase (.33)		
	30-Day Follow-Up (.5)	Follow-Up After Hospitalization for Mental Illness	12.5
	7-Day Follow-Up (.5)		
		Beta Blockers Following AMI	25
	Beta Blockers Post AMI		
	LDL-C Screening (.33)	Cholesterol Management	25
	LDL-C Level* (.66)		
		Appropriate Treatment for Children with Upper Respiratory Infection	12.5
		Appropriate Testing for Children with Pharyngitis	12.5
			100
Living With Illness		Controlling High Blood Pressure	33.3
		Use of Appropriate Medications for People With Asthma	33.3
	Ages 5-9 (.33)		
	Ages 10-17 (.33)		
	Ages 18-56 (.33)		
		Comprehensive Diabetes Care	33.3
	HbA1c Screening (.125)		
	HbA1c <9.5 (.25)		
	Retinal Screening (.125)		
	Lipid Screening (.125)		
	Lipid Level* (.25)		
	Nephropathy Monitoring (.125)		
			100

**Component measures that sum to < 1.0 are carried to 3 digits (e.g., .333)
^Weights are renormalized to 1.0 if total < 1.0
*LDL < 130 is numerator based measure for LDL control measures in which two measures are reported: LDL <130 and LDL <100

Appendix C
2005 Performance Category Grade Cutpoints

Staying Healthy Grades

<60 = poor
60-69 = fair
70-79 = good
80-100 = excellent

The interpretation of the 2005 grades is:

Excellent: a positive result occurred for more than 80% of enrollees
Good: a positive result occurred for roughly ¾ of enrollees
Fair: a positive result occurred for roughly 2/3 of enrollees
Poor: a positive result occurred for fewer than 60% of enrollees

Living with Illness Grades

<50 = poor
50-59 = fair
60-69 = good
70-100 = excellent

The interpretation of the 2005 grades is:

Excellent: a positive result occurred for more than 70% of enrollees
Good: a positive result occurred for roughly 2/3 of enrollees
Fair: a positive result occurred for upwards of half of enrollees
Poor: a positive result occurred for fewer than half of enrollees

Getting Better Grades

<60 = poor
60-69 = fair
70-79 = good
80-100 = excellent

The interpretation of the 2005 grades is:

Excellent: a positive result occurred for more than 80% of enrollees
Good: a positive result occurred for roughly ¾ of enrollees
Fair: a positive result occurred for roughly 2/3 of enrollees
Poor: a positive result occurred for fewer than 60% of enrollees

Appendix D
Missing Value and "No Info" Decisions

There was a single missing value in the 2005 HEDIS data set – that health plan did not have a 2005 or a 2004 result. The composite score was constructed using the available measures scores for that topic.

Appendix E
CCHRI Health Plan Reporting Status
For Reporting Year 2005

Health Plan	HEDIS	CAHPS
Aetna	Yes	Yes
Blue Cross	Yes	Yes
Blue Shield	Yes	Yes
CIGNA	Yes	Yes
HealthNet	Yes	Yes
Kaiser North	Yes	Yes
Kaiser South	Yes	Yes
PacifiCare	Yes	Yes
Universal Care	Yes*	Yes
Western Health Advantage	Yes*	Yes

* HEDIS not reported through CCHRI

Appendix F
Health Plan Statistical Significance Test 2005

Any score that lies within the two extreme performance grades (excellent or poor) is tested to determine if that score is significantly different ($p < .05$) than the all-HMO mean score for that performance category (e.g. Staying Healthy). The test was applied to all three composite scores: Staying Healthy, Getting Better, Living with Illness.

The composite scores for each plan are calculated on the basis of all available component measure rates:

$$C_g = \frac{\sum_{k=1}^{J_g} w_k r_{gk}}{\sum_{k=1}^{J_g} w_k}$$

Where r_{gk} is the rate for component k and plan g, w_k is the weight for component k, and where plan g has J_g component measure rates.

Missing Values: The above formula incorporates the handling of missing values. If all a plan has reportable rates for all measures, the sum of the weights (the denominator in the above formula) equals one. If a plan has a missing rate for one or more measures, the denominator will be less than one, effectively "scaling up" the composite rate based on the weights of the available measures, so that the missing value does not adversely affect the plan's composite score.

The variance of the composite score for plan g is:

$$V_g = \frac{\sum_{k=1}^{J_g} w_k^2 \cdot r_{gk}(1-r_{gk})/n_{gk}}{\left(\sum_{k=1}^{J_g} w_k\right)^2}$$

Where n_{gk} is the sample size (at least 30) for component rate k and plan g. The component variances in the sum are based on the binomial distribution.

Each plan's composite score is compared to the overall, unweighted mean of the plan composites:

$$C = \frac{\sum_{g=1}^{G} C_g}{G}$$

Where there are a total of G plans.

The variance of C is:

$$V = \frac{\sum_{g=1}^{G} V_g}{G^2}$$

Finally, the test statistic for group g is:

$$t_g = \frac{C_g - C}{\sqrt{V_g + V}}$$

Asymptotically, this statistic has a standard normal distribution. Consequently, at the 5 percent significance level, the group composite is significantly different from the overall mean composite if $t_g < -1.96$ or if $t_g > +1.96$.

CAHPS 2005 SCORING GUIDELINES

CONSUMER REPORTING METHODS FOR OFFICE OF PATIENT ADVOCATE AND PBGH HEALTHSCOPE

I. Eligible Measures and Plans

The eligible measures consist of the CAHPS* commercial measures for reporting year 2005. The 10 California Cooperative HealthCare Reporting Initiative's (CCHRI) 2005 participating plans listed in Appendix D are the eligible plans.

Performance results are reported at a health plan reporting unit level. With the exception of Kaiser Northern California and Kaiser Southern California the plans report a single, statewide set of performance results.

II. Measures

The "Member Rating of Plan" global health plan rating item (Q. 49) is reported as the summary indicator of member-reported plan experience.

The following composites and items are reported in addition to the summary measures:

- Getting Doctors and Care Easily (e.g., Getting Needed Care)
- Plan Customer Service
- Paying Claims
- Health Care Highly Rated
- Doctor Communications
- Getting Appointments and Care Quickly (e.g., Getting Care Quickly)
- Member Complaints (Q43)
- Smoking Cessation (Q55, Q56, Q57)

The three Smoking Cessation Measures are reported as individual measures only – they are not reported as a composite or as a summary topic. Seven of the CCHRI plans' completed survey respondent sample counts met the target minimum of 100 respondents. Per the CCHRI rule if a minimum of 3 plans have reportable scores the measure is publicly reported for those plans that have reportable scores.

The member complaints handled quickly measure (Q. 44) is not reported as too few plans had reportable results given low denominator counts.

* Consumer Assessment Health Plan Survey (CAHPS) NCQA sponsors the CAHPS member reported experience and satisfaction survey measures as the national standard health plan member survey.

III. Handling CAHPS Missing or Inappropriate Response Data

The NCQA CAHPS missing values and inappropriate response data (respondent answers a question that should have been skipped) rules are used. In instances in which a CAHPS survey question was not answered, we remove the question from the respondent's record: for questions that were part of composite scales we calculated the score using that member's responses to the remaining questions for that composite. In the case of questions that were not part of a composite scale we removed that question from the HMO total responses for that item and calculated the score using the responses of the remaining HMO members.

No plan result is reported for a measure if the NCQA CAHPS 100 minimum respondents per question standard is not achieved.

IV. Scoring

All of the performance results are expressed such that a higher score means better performance.

Individual and Composite Measure Scoring

All values are rounded to whole number per vendor applied rounding rule.

The NCQA 3.0H scoring rules, for proportional scoring, are used to create the CAHPS individual measure and composite global proportion scores.

Eleven scores are produced representing the composites and single items listed in Appendix A Tables 1 & 2. Five composite scores, two global rating scores, and four individual items are reported.

See Appendix B for the composite scoring formula and Appendix C for the response choice recoding used.

The "Member Rating of Plan," the global health plan rating item (Q. 49), is reported as the single summary performance score. The CAHPS proportional scoring rule is applied per the recode values listed in Appendix C.

V. Performance Grading

A grade is assigned to the single summary performance score – each HMO's CAHPS performance is characterized by a performance grade along with the composite and item measures results.

An absolute grading approach is used to assign a grade for the CAHPS summary performance category. The plan's summary performance score is assigned a grade based on the position of the actual score relative to a set of performance thresholds on a 0-100 scale. The performance thresholds are absolute not relative markers of performance. The performance grade is based on the performance thresholds listed below.

Grade Cutpoints

<50 = poor
50-59 = fair
60-69 = good
70-100 = excellent

Sampling Error Testing

Any Member Rating of Health Plan score that lies within the two extreme performance grades (excellent or poor) is tested to determine if that score is significantly different ($p < .05$) than the all-HMO mean score* for the summary performance category (e.g. Member Rating of Health Plan). Scores that are not significantly different than the mean (the confidence limit for the plan in question must include the all-HMO mean score) are reclassified to the adjacent performance grade so a poor grade would be shifted to fair and an excellent grade shifted to a good.

*Note: the all HMO mean is based on the CCHRI 2005 commercial HMO plans (it does not include PPO plans).

Appendix A
Table 1. Getting Doctors and Care Easily, Paying Claims and Plan Customer Service Composites, Global Health Plan Rating and Member Complaint Items

Q.	Survey Item	Composite or Topic
9	In the last 12 months, how much of a problem, if any, was it to see a specialist that you needed to see? (a big problem-not a problem)	Getting Doctors and Care Easily
24	In the last 12 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary? (a big problem-not a problem)	Getting Doctors and Care Easily
26	In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan? (a big problem-not a problem)	Getting Doctors and Care Easily
7	Since you joined your health plan how much of a problem, if any, was it to get a personal doctor or nurse you are happy with? (a big problem-not a problem)	Getting Doctors and Care Easily
36	In the last 12 months, how often did your health plan handle your claims in a reasonable time? (never-always)	Paying Claims
37	In the last 12 months, how often did your health plan handle your claims correctly? (never – always)	Paying Claims
38	In the last 12 months, before you went for care, how often did your health plan make it clear how much you would have to pay? (never – always)	Paying Claims
48	In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan? (a big problem-not a problem)	Plan Customer Service
40	In the last 12 months, how much of a problem, if any, was it to find or understand this information? (a big problem-not a problem)	Plan Customer Service
42	In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service? (a big problem-not a problem)	Plan Customer Service
43	In the last 12 months, have you called or written your health plan with a complaint or problem?	Member Complaints
49	What number would you use to rate your health plan? (0-10)	Global Plan

Appendix A

Table 2. Getting Appointments and Care Quickly and Doctor Communications Composites, Health Care Highly Rated and Advice to Quit Items

Q.	Survey Item	Composite or Topic
14	In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed? (never-always)	Getting Appointments and Care Quickly
16	In the last 12 months, when you needed care right away for an illness, injury or condition, how often did you get care as soon as you wanted? (never-always)	Getting Appointments and Care Quickly
19	In the last 12 months, not counting the times you needed health care right away, how often did you get an appointment for health care as soon as you wanted? (never-always)	Getting Appointments and Care Quickly
27	In the last 12 months, how often were you taken to the exam room within 15 minutes of your appointment? (never-always)	Getting Appointments and Care Quickly
30	In the last 12 months, how often did doctors or other health providers listen carefully to you? (never-always)	Doctor Communication
31	In the last 12 months, how often did doctors or other health providers explain things in a way you could understand? (never-always)	Doctor Communication
32	In the last 12 months, how often did doctors or other health providers show respect for what you had to say? (never-always)	Doctor Communication
33	In the last 12 months, how often did doctors or other health providers spend enough time with you? (never-always)	Doctor Communication
34	What number would you use to rate all your health care (0-10)?	Health Care Highly Rated
55	In the last 12 months, on how many visits were you advised to quit smoking by a doctor or other health provider in your plan? (none-10+ visits)	Helping Smokers Quit: Getting Advice
56	On how many visits was medication recommended or discussed to assist you with quitting smoking?	Helping Smokers Quit: Medications
57	On how many visits did your doctor or health provider recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking?	Helping Smokers Quit: Ways to Stop

Appendix B Scoring
CAHPS Summary Roll-up
Scoring Method

The composite and global measures are scored per the NCQA 3.0H "Guidelines for Calculating Summary Results (pgs 189-209 of the HEDIS 2003 Volume 3 Specifications for adult, commercial product line).

1. Each response choice is recoded to a two-point scale per the table listed in Appendix C. In all cases a higher score indicates better performance.

2. Calculate the proportion of respondents, within each plan, who selected each response choice per the following example for the composite:

Member	Q28 Member Response	Q28 Rescaled Response Value	Q29 Member Response	Q29 Rescaled Response Value
1	Always	1	Usually	1
2	Sometimes	0	Sometimes	0
3	Never	0	Sometimes	0
4	Missing Data		Always	1
5	Usually	1	Usually	1
Always		.25		.20
Usually		.25		.40
Sometimes or Never		.50		.40

3. Calculate the average proportion responding to each response category for each composite:

Always (.25 +.20) = .225
Usually (.25+.40) = .325
Sometimes/never (.50 + .40) = .45

4. Calculate the proportion of positive responses by summing the proportion of always and usually responses:

Always + Usually (.225+.325) = 55%

5. The unweighted composite score for this plan equals 0.55

Appendix C
Response Choice Recodes
NCQA Proportional Scoring

CAHPS Scale or Question	*Recoded Score Value*
Problem scale*	not a problem = 1 small problem = 0 big problem = 0
0-10 scale**	8, 9, 10 = 1 0-7 = 0
Never-always scale*	Always = 1 Usually = 1 Sometimes = 0 Never = 0
Q43. Have you called or written your health plan with a complaint or problem?	No = 1 Item is scored such that higher is better: numerator is sum of "no" responses

* Page 207 of 3.0H Guidelines for Calculating Summary Results
** Page 195 of 3.0H Guidelines for Calculating Summary Results

Appendix D
CCHRI Health Plan Reporting Status
For Reporting Year 2005

Health Plan	CAHPS
Aetna	Yes
Blue Cross	Yes
Blue Shield	Yes
CIGNA	Yes
HealthNet	Yes
Kaiser North	Yes
Kaiser South	Yes
PacifiCare	Yes
Universal Care	Yes
Western Health Advantage	Yes

Consumer Assessment Survey (CAS) 2005

Consumer Reporting Methods for Office of Patient Advocate and PBGH HealthScope

I. Composite Scoring

Composite scores are calculated for four summary topics:

- Timely Care and Service
- Coordinating Patient Care
- Getting Treatment and Specialty Care
- Communicating with Patients

1. scoring is done on a per respondent basis
2. a respondent is eligible if the respondent answered at least 50% of the items in the composite
3. missing value: if an item is not answered the question value is removed from the denominator and the respondent's mean score is based on the remaining questions
4. item response values assigned per the item response table below
5. mean score is calculated for each individual's responses to all items in a composite (so a respondent whose response choices equaled 3, 2, 2, and 1 for the 4 communications items was scored (3+2+2+1)/4 = 2.0)
6. the per respondent mean score, for all items, is adjusted for age, education, health status and perceived mental health status differences among groups: a non-response weight was applied to each respondent score. The non-response weight is based on the demographics of the original CAS sample frame (all eligible patients that were drawn from medical group records). This non-response weight is an age and gender stratification step to adjust for patients who did not respond and weight the group's results to represent the original population from which the patients were sampled.
7. a mean of the individual respondent means is calculated to create a medical group level score: step 1: calculate mean score for the medical group (e.g., (3+2+1)/3) and step 2: convert the medical group means score to a 0-100 scale [(medical group mean score – lowest possible value ÷ highest possible value – lowest possible value) x 100 = medical group score]

(2.0 - 1.0/3.0 – 1.0) x 100

8. Each item in each composite is equally weighted.

Table 1: Question Composition of Composite/Summary Topics

Composite/Summary Topic	Composite/Summary Topic Questions
Communicating with Patients	Q8, Q9, Q10, Q11
Timely Care and Service	Q2, Q3, Q4, Q7, Q18, Q19, Q20, Q25
Getting Treatment and Specialty Care	Q6, Q27, Q29, Q30
Coordinating Patient Care	Q 21, Q22, Q31
Patient Rating of Care	Q14

II. Display/Exclusion of Miscellaneous Items

The following two items will be scored as the "Helpful Office Staff" composite but they will not be included as a summary topic composite per the ones listed in Table 1 above. This Helpful Office Staff composite will be scored using the proportional scoring formula.

> Q.12. In the last 12 months, how often did office staff at your doctor's office or clinic treat you with courtesy and respect (nested as part of Composite in Timely Care and Service drill-down)
>
> Q. 13. In the last 12 months, how often were office staff at your doctor's office or clinic as helpful as you thought they should be? (nested as part of Composite in Timely Care and Service drill-down)

The following five items are not used in the consumer reporting:

> Q. 23 What number would you use to rate your personal doctor or nurse.
>
> Q. 33 When you next have a chance, do you plan to change to a different doctor's office or clinic because you are unhappy with your care?
>
> Q. 32 What number would you use to rate the specialist you saw most often in the last 12 months.
>
> Q. 15 In the last 12 months, did your personal doctor, nurse or other health professional talk with you or give you information about how much or what kind of foods you eat?
>
> Q. 16 In the last 12 months, did your personal doctor, nurse, or other health professional talk with you or give you information about how much or what kind of exercise you get?

Table 2. Response Choice Values

Item Response Set	Response Choice Value Mean Scoring	Response Choice Value Proportional Scoring
Never-always	Always = 3 Usually = 2 Sometimes = 1 Never = 1	Always = 1 Usually = 1 Sometimes = 0 Never = 0
Never, sometimes, always (Q22)	Always = 3 Sometimes = 2 Never = 1	Always = 1 Sometimes = 0 Never = 0
Problem (Q6 and Q27)	Not a problem = 3 Small problem = 2 Big problem = 1	Not a problem = 1 Small problem = 0 Big problem = 0
0-10 Global	Item scored as a continuous variable: 0=0; 1 =.1; 2=.2; 3=.3; 4=.4; 5=.5; 6= .6; 7=.7; 8=.8; 9=.9; 10=1.0	8, 9, 10 = 1 0-7 = 0
Yes – no (Q15, Q16)	Yes = 1 No = 0	Yes = 1 No = 0

III. Q. 14 Global Rating Question Scoring

1. the global health care rating item is scored by calculating a mean score per respondent
2. the response choices are treated as a continuous variable (0 = 0; 1 = .1…10 =1.0)
3. the medical group mean score is calculated by: step 1: summing the individual respondent item response values and dividing that total by the total number of responses for the item and step 2: multiplying that straight mean by 10:

$$(5+7+9)/3 \times 10 = 70$$

4. non-response weighting and case mix adjustment described above also used here

IV. Individual Question Scoring

1. scoring is done on a per question basis
2. item response values, using the proportional method, are assigned per the item response table above
3. for each item response a 0/1 score is assigned (a 1 assigned for a "positive result" and a 0 for a "negative result")
4. the medical group proportional score is calculated by summing the number of positive results for each item and dividing the number of positive results by the number of eligible responses.
5. non-response weighting and case mix adjustment described above also used here
6. Q.25 After Hours Care is scored by combining the results for the 2004 and 2005 surveys for those groups that participated in both years; if 2004 results are not available then only 2005 results are used.

V. Grading

Apply the grade cutpoints listed in Table 3 on page 4 to assign the performance grades.

Any medical group score that is placed in the extreme performance grades (excellent or poor) is tested to determine if that score is significantly different (p = .05) than the respective regional medical group mean score (northern California mean or Southern California mean) for that performance category (e.g., communicating with patients). Scores that are not significantly different than the mean are reclassified in the adjacent performance grade so a poor grade would be shifted to fair and an excellent grade shifted to a good.

Table 3. Grade Cutpoints

Overall Health Care Rating 2005 CAS Grade		
Grade	**Interpretation**	**Grade Cutpoints***
Excellent	80% or more of patients reported positive experiences	85+
Good	3/4 or more of patients reported positive experiences	84-80
Fair	2/3 or more of patients reported positive experiences	79-75
Poor	40% or more of patients rated their experience unfavorably	<75

Timely Care and Service 2005 CAS Grade		
Grade	**Interpretation**	**Grade Cutpoints***
Excellent	80% or more of patients reported positive experiences	65+
Good	3/4 or more of patients reported positive experiences	64-60
Fair	2/3 or more of patients reported positive experiences	59-50
Poor	40% or more of patients rated their experience unfavorably	<50

Coordinating Patient Care 2005 CAS Grade		
Grade	**Interpretation**	**Grade Cutpoints***
Excellent	3/4 or more of patients reported positive experiences	70+
Good	70% of patients reported positive experiences	69-65
Fair	2/3 of patients reported positive experiences	64-55
Poor	40% or more of patients rated their experience unfavorably	<55

Getting Treatment and Specialty Care 2005 CAS Grade		
Grade	**Interpretation**	**Grade Cutpoints***
Excellent	3/4 or more of patients reported positive experiences	75+
Good	70% of patients reported positive experiences	74-70
Fair	2/3 or more of patients reported positive experiences	69-60
Poor	40% or more of patients rated their experience unfavorably	<60

Communicating with Patients 2005 CAS Grade		
Grade	**Interpretation**	**Grade Cutpoints***
Excellent	90% or more of patients reported positive experiences	75+
Good	80% or more of patients reported positive experiences	74-70
Fair	3/4 of patients reported positive experiences	69-60
Poor	40% or more of patients rated their experience unfavorably	<60

*these cutpoints are based on mean scores; they are not based on percentage/proportional results

IHA 2005 Getting the Right Medical Care

Consumer Reporting Methods for Office of Patient Advocate and PBGH HealthScope

Measures: Summary and Individual

There are seven eligible measures (Table 1) that can be combined and scored to report the summary rate "Getting the Right Medical Care."

Table 1

Individual Measures	Summary Measure
Breast Cancer Screening Cervical Cancer Screening Asthma Medications All Ages Cholesterol Testing Diabetes - HbA1cTesting Chlamydia Screening All Ages Childhood Immunizations	Getting the Right Medical Care

These measures also are presented as seven individual measures on the OPA web site. Additionally, the Controlling Cholesterol and Controlling Blood Sugar measures are reported as individual measures only; these two measures are not among the eligible measures for the Getting the Right Medical Care summary rate.

Scoring

Individual Measure Scoring

The proportional scores for each individual measure are calculated per the IHA Pay for Performance scoring rules. A Childhood Immunization measure score is calculated as the unweighted average of the MMR and the VZV antigen scores. The Controlling Blood Sugar measure is reverse scored (e.g., higher is better). The Asthma Medication All Ages and Chlamydia Screening All Ages measures are the sum of their respective age cohort numerators and denominators.

Summary Performance Category Scoring

A summary score is calculated for any group that has four or more reportable measures. The seven eligible measures for the summary Getting the Right Medical Care are listed in Table 1. Controlling Cholesterol and Controlling Blood Sugar measures are not eligible measures for the summary score

For each medical group, a summary score is calculated as the simple average of the available 4, 5, 6 or 7 rates. For the Childhood Immunization measure, if one of these two antigen rates is missing then the non-missing rate is used for the component score. No missing value imputation is used – results are calculated based on the available measures.

A rounding rule is applied to round the summary score up/down to nearest whole integer.

Grading

For each medical group, using the grade ranges listed in Table 2 below, a grade is assigned for the summary score Getting the Right Medical Care.

For each medical group whose composite Getting the Right Medical Care score is graded either Excellent or Poor that score is compared to the cross-group mean for the composite. The cross-group mean is based on the all-medical group reportable composite score (i.e., where groups have four or more reportable measures). It is not limited to measures for which the group had a reportable score.

If the plan score is not statistically significantly different from the cross-group mean, that group's score is shifted into the neighboring grade category (i.e., Excellent will become Good and Poor will become Fair). See description of statistical significance test below.

The performance grade cutpoints are as follows:

Table 2

2005 IHA Grades				
Legend	*Poor*	*Fair*	*Good*	*Excellent*
Score Cutpoint	< 50	50-64	65-79	80+
Statistical Test to Maintain Grade	(statistically below average)			(statistically above average)

Statistical Significance Test

The composite score for each group is calculated on the basis of up to seven component rates:

$$C_g = \frac{\sum_{k=1}^{J_g} r_{gk}}{J_g}$$

Where r_{gk} is the rate for component k and group g, and where group g has J_g components (but at least four).

The variance of the composite score for group g is:

$$V_g = \frac{\sum_{k=1}^{J_g} r_{gk}(1-r_{gk})/n_{gk}}{J_g^2}$$

Where n_{gk} is the sample size (at least 30) for component rate k and group g. The component variances in the sum are based on the binomial distribution.

For "CIS Average", when the score is an average of the two rates (CIS MRR and CIS VZV), the variance is calculated as the sum of the individual rate variances (=rate*(1-rate)/n) divided by 4.

Each group's composite score is compared to the overall, unweighted mean of the group composites:

$$C = \frac{\sum_{g=1}^{G} C_g}{G}$$

Where there are a total of G groups. The variance of C is:

$$V = \frac{\sum_{g=1}^{G} V_g}{G^2}$$

Finally, the test statistic for group g is:

$$t_g = \frac{C_g - C}{\sqrt{V_g + V}}$$

Asymptotically, this statistic has a standard normal distribution. Consequently, at the 5 percent significance level, the group composite is significantly different from the overall mean composite if $t_g < -1.96$ or if $t_g > +1.96$.